MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07889 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs 1 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 6 yrs 1 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: [illegible]

City or town: Baltimore Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ester Adelsberger

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 5th - 1895

8. AGE:

Years	Months	Days	If less than one day
50	11	12	hrs. min.

9. Birthplace: Maryland.
(Town, county, and state)

10. Usual occupation: Dependent.

11. Industry or business:

FATHER 12. Name: John F Adelsberger

13. Birthplace: Md

MOTHER 14. Maiden name: Ella Duphorn

15. Birthplace: Md

16. Informant: Ruth M. Adelsberger

Address: 1712 Clifford St Balto

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Aug 19 1946
(month) (day) (year)

Cemetery or crematory: Luther Emanuel Cem

Location: Emanuel Church

18. Funeral director: W Z Welsh

Address: Thurmont

19. Aug 17 1946 C. Harry Eckert
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 17th 1946 at 5.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1946, to Aug 17 1946 and that I last saw h[illegible] alive on Aug 16 1946

Immediate cause of death	DURATION
Chronic Myocarditis	10 yrs
Due to	
Epilepsy	45 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jos J Gaston Jr M.D.
M. D. or other

Address: Sykesville Date signed: 8/17/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

07890

Reg. Dist. No. 80

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mollie Albaugh

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 21 - 1864

8. AGE: Years: 82 Months: 5 Days: 8 If less than one day: ..... hrs. ..... min.

9. Birthplace: Frederick County, Md (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: At home

FATHER

12. Name: Charles A. Albaugh

13. Birthplace: Maryland

MOTHER

14. Maiden name: Julia L. Rout

15. Birthplace: Maryland

16. Informant: Mrs. Nella Albaugh

Address: Uniontown, Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept 1 - 1946 (month) (day) (year)

Cemetery or crematory: Beaver Dam Cemetery

Location: Union Bridge R.D. 3

18. Funeral director: H. H. Gaither & Sons

Address: Union Bridge & New Windsor, Md

19. Sept 1, 1946 (Date rec'd by registrar) Emma L. Bunder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29th 19 46, at 9:50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 29 19 46, to Aug 29 19 46

and that I last saw h alive on Aug 29 19 46

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Base of Brain	
Due to: Arterio Sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other

Address: Union Bridge Date signed: 8-30-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85a

07891

CERTIFICATE OF DEATH

Reg. Diat. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. 513 E. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Aprile

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

B.(b) Name of husband or wife: Sebastina Aprile

B.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): April 27, 1888

8. AGE: Years	Months	Days	If less than one day
58	4	2	....hrs. ....min.

9. Birthplace: Ragusa, Siracusa, Italy (Town, county, and state)

10. Usual occupation: Retail grocer (retired)

11. Industry or business

FATHER — 12. Name: Giovana Battista Aprile

13. Birthplace: Italy

MOTHER — 14. Maiden name: Chessari Rosaria

15. Birthplace: Italy

16. Informant: Mrs. George Aprile

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 8/31/46 (month) (day) (year)

Cemetery or crematory: St. John's Catholic Cem.

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 8/25/46 (Date rec'd by registrar) H. Allen Goodrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29th 1946, at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 28 1946, to August 29 1946, and that I last saw him alive on August 29 1946

Immediate cause of death	DURATION
Acute Cerebral Hemorrhage	1 hour
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Luther Bosa (M.D.) M. D. or other

Address: Westminster, Md. Date signed 8/31/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10-C)

CERTIFICATE OF DEATH

07892

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Westminster (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Klees Mill Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 563 Bond Street (If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: William Benjamin Bailey

3. (b) Social Security Number: 218-10-6276

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	single

B.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 1, 1893

8. AGE: Years	Months	Days	If less than one day
52	8	11	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Arthur Bailey

13. Birthplace: Westmoreland Co. Va.

MOTHER — 14. Maiden name: M. Bailey?

15. Birthplace: Va.

16. Informant: Mrs Bertha Washington

Address: 1428 Argyle Ave. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 16. 46 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Baltimore, Md.

18. Funeral director: George B. Kelson

Address: 1307 Predstmon St. Balto. Md.

19. 8/13 1946 (Date rec'd by registrar) G. Kelson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 12 1946 at 7:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Multiple fracs. right thigh & leg	
Fracture Dist. femur	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide or homicide: Accident Date of 8-12-46

Where did injury occur? Rural (City or town) Westminster (County) Carroll (State) Md

Injured at home, farm, industry, public place (where?) Klees Mill Road

Means of injury: Auto accident Injured at work? Yes

23. SIGNATURE: James T. Monk Deputy Medical Examiner M. D. or other

Address: Westminster Md Date signed 8/12/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07893

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Queen Anne's
City or town: Queenstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: FRANK GEORGE BENTLEY

3.(b) Social Security Number: 219-05-1943

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 8, 1896

8. AGE:	Years	Months	Days	If less than one day
	50	1	4	hrs. min.

9. Birthplace: Queenstown, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Thomas Bentley
13. Birthplace: Talbot County, Md.

MOTHER
14. Maiden name: Georgianna Pratt
15. Birthplace: Talbot County, Md.

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 16 1946 (month) (day) (year)
Cemetery or crematory: Sandtown, Md.
Location: Near Hillsboro, Md
18. Funeral director: J. Virgil Noon & Son
Address: Denton, Md.

19. 8/12 (Date rec'd by registrar) 19 46 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 12, 1946 at 7.00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1, 1946 to Aug. 12, 1946 and that I last saw him alive on August 12, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1, 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Shuman M.D
M. D. or other
Address: Henryton, Md. Date signed 8/12/46.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

07894 ★ Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Carroll
City or town: Near Uniontown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Carroll
City or town: near Uniontown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Henry Bergen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: /
7. Birth date of deceased (mo., day, yr.): July 29-46
6.(c) If alive, give age ..... years

8. AGE:

Years	Months	Days	If less than one day
0	0	29	..... hrs. ..... min.

9. Birthplace: Carroll Co
(Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Harry Edward Bergen
13. Birthplace: Carroll Co. Md.

MOTHER
14. Maiden name: Pauline Marg. Pittinger
15. Birthplace: Carroll Co

16. Informant: Mrs. Pauline M. Bergen
Address: Union Bridge Rt 1
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 29 46 (month) (day) (year)
Cemetery or crematory: Chr. of God
Location: Uniontown
18. Funeral director: C. O. Fuss & Son
Address: Taneytown Md
19. Aug 29 1946 (Date rec'd by registrar) Margaret P. Englar (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 27 1946, at 3 45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 25 1946, to Aug 27 1946
and that I last saw h[illegible] alive on Aug 26 1946

Immediate cause of death	DURATION
Mal Nutrition	
from birth	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other
Address: Union Bridge Md Date signed 8-27-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

07895

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. Farquhar Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Nettie Virginia Bloom

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Harvey C. Bloom

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 26-1877

8. AGE: Years	Months	Days	If less than one day
69	5	2	...hrs. ...min.

9. Birthplace Carroll County Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at Home

FATHER — 12. Name Aaron Routzon

FATHER — 13. Birthplace Maryland.

MOTHER — 14. Maiden name Mary Martin

MOTHER — 15. Birthplace Maryland

16. Informant Mr. Donald Bloom

Address Union Bridge Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 31-1946 (month) (day) (year)

Cemetery or crematory Mountain View Cemetery

Location Union Bridge Md

18. Funeral director D. D. Hartzler & Son

Address Union Bridge & New Windsor Md

19. Aug 30 1946 (Date rec'd by registrar) Wickman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1946, at 10.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 24 1946 to Aug 28 1946 and that I last saw her alive on Aug 28 1946

	DURATION
Immediate cause of death Cerebral hemorrhage	4 days
Due to Bone of brain	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Eggman M. D. or other

Address Union Bridge Date signed 8-30-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 415 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

07896

CERTIFICATE OF DEATH

Reg. Diat. No. 79

1. PLACE OF DEATH:

County Carroll

City or town Middleburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Middleburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Henry Bowman

3. (b) Social Security Number 705-10-6018

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband or wife~~ Violet Pearl Bowman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 28, 1883

8. AGE:

Years	Months	Days	If less than one day
63	6	11	..... hrs. ..... min.

9. Birthplace Middleburg Carroll Co. Md.

(Town, county, and state)

10. Usual occupation Railroad Employee

11. Industry or business Store keeper

FATHER

12. Name Charles Henry Clay Bowman

13. Birthplace Maryland

MOTHER

14. Maiden name Rachael Flickinger

15. Birthplace Maryland

16. Informant C. S. Bowman

Address Union Bridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 11, 1946 (month) (day) (year)

Cemetery or crematory Middleburg Cemetery

Location Middleburg, Md.

18. Funeral director C. O. Fuss & Son

Address Taneytown, Md.

19. Aug 9 1946 (Date rec'd by registrar) Emma M. Kiser Powell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1946 at 9 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1946 to Aug. 8 1946

and that I last saw him alive on Aug. 7 1946

Immediate cause of death	DURATION
Coronary Occlusion	Few min.
Due to Coronary Artery Sclerosis and Chronic Myocarditis	5 yrs. 5 yrs.
Due to	
Other conditions Cerebral Arteriosclerosis	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation None Done Date of op.

Autopsy results None Done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M.D. M. D. or other

Address Taneytown, Md. Date signed 8/8/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07897

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 month,
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 612 Cumberland St.,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JOSEPH BRADFORD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 23, 1926

8. AGE:

Years	Months	Days	If less than one day
20	3	10	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Malcolm Bradford
13. Birthplace: Harford County, Md.

MOTHER
14. Maiden name: Mable Franklin
15. Birthplace: Anne Arundel County, Md.

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-7-46 (month) (day) (year)
Cemetery or crematory: Mt. Gilboa.
Location: Baltimore City

18. Funeral director: Geo. H. Kelson
Address: 1303 Presstman. St.

19. 8/3 (Date rec'd by registrar) 19 46 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 3, 19 46, at 2.00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 3, 19 45, to Aug. 3, 19 46
and that I last saw him alive on August 3, 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 27th 1944
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hyman M.D.
M. D. or other
Address: Henryton, Md. Date signed: 8/3/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07898 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 1 day
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 324 N. Carey Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ELIZABETH BUTLER

3.(b) Social Security Number: 213-20-1075

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 25, 1923

8. AGE: Years	Months	Days	If less than one day
23	3	27	hrs. min.

9. Birthplace: Winsboro, S. C. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Alfred Butler
13. Birthplace: South Carolina.

MOTHER
14. Maiden name: Phyllis Gunthroy
15. Birthplace: South Carolina

16. Informant: Bessie Cherry
Address: 324 N. Carey St. Baltimore, Md.

17. Shipped. (Burial, cremation, or removal. Which?) Date thereof: Aug 27 46 (month) (day) (year)
Cemetery or crematory:
Location: Winsboro S. C.
18. Funeral director: Mrs. Ida P. Williams
Address: 3222 Schroder Ave

19. 8/23 19 46 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 23, 1946, at 2.50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22, 1946, to Aug. 23, 1946 and that I last saw her alive on August 23, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 15 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 8/23/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07899

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium(Colored)
How long in hospital or institution? same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1710 Etting Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES MATTHEW CARTER

3.(b) Social Security Number: 218-10-3540

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 8, 1900

8. AGE: Years	Months	Days	If less than one day
45	11	9	hrs. min.

9. Birthplace: Hampton, Va.
(Town, county, and state)

10. Usual occupation: Presser

11. Industry or business

FATHER
12. Name: Matthew Carter
13. Birthplace: Williamsburg, Va.

MOTHER
14. Maiden name: Cora Banks
15. Birthplace: Hampton, Va.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-21-46 (Month) (day) (year)
Cemetery or crematory: Mt Calvery
Location: A A Co Md
18. Funeral director: Adolphus Halstead
Address: 918 Druid Hill Ave.

19. Aug. 17 1946 (Date rec'd by registrar) Albert R Swanborn deputy local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 17 1946 at 11:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 15 1946 to Aug. 17 1946 and that I last saw him alive on Aug. 17 1946

Immediate cause of death	DURATION
Pulmonary tuberculosis	May 1944
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Md. Date signed 8-17-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

07900

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 - 1 - 3
Hospital, Institution, or street address where death occurred:
Carroll home of the aged
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Westminster Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Annie Cassell Clarke

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband ~~or wife~~ Edward V. Clarke
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 5 - 1868

8. AGE:

Years	Months	Days	If less than one day
78	5	7	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name Reuben Cassell
13. Birthplace Carroll Co. Md.
MOTHER 14. Maiden name Margaret Schweigert
15. Birthplace Carroll Co. Md.
16. Informant W. H. Harris
Address Westminster, Md.
17. Burial Date thereof 8/14/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Westminster Cemetery
Location Westminster, Md.
18. Funeral director H. Bankard Sons
Address Westminster Md.
19. 8/13/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12, 1946, at 2.30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan 20 1946, to 1946
and that I last saw h.er alive on Aug 11 1946

Immediate cause of death	DURATION
2nd Cerebral hemorrhage	4 days
Due to arteriosclerosis,	
Due to	
Other conditions Previous cerebral hemorrhage with hemyplegia	2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE. E. Reese Wilkens M.D.
M. D. or other
Address Westminster Date signed 8-13-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

CERTIFICATE OF DEATH

07901 74

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45.15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months, 4 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 10 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George J. Curry

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

6.(b) Name of husband or wife: Anna Linhardt

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 13, 1871

8. AGE: Years	Months	Days	If less than one day
74	9	20	hrs. min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)

10. Usual occupation: Printer

11. Industry or business: Job printing

FATHER 12. Name: William Curry

FATHER 13. Birthplace: Ireland

MOTHER 14. Maiden name: Margaret Rauh

MOTHER 15. Birthplace: Bohemia

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 7/46 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Belair Road.

18. Funeral director: Wm. Coors Inc

Address: St. Paul & Preston Sts.

19. Filed Aug 9 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 3 1946, at 8:40p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 21 1945, to Aug. 3 1946 and that I last saw him alive on August 3 1946

Immediate cause of death	DURATION
Arteriosclerosis	18 mo.
Due to: xxx Cancer of the skin (of the face)	unknown
Due to:	
Other conditions: Senile psychosis, paranoid type	18 mo.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
M. D. or other

Springfield State Hospital
Address: Sykesville, Maryland

Date signed: 8-3-46

Evidence for change of age of deceased is shown on FILM No. I 06 SEP 10 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

07902 70
Reg. Dist. No.

1. PLACE OF DEATH:
County Carroll
City or town Taneytown - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Taneytown - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mervin R. Diehl

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Margie Baumgardner
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1885

8. AGE: Years	Months	Days	If less than one day
61 -00-	6	7	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name George A. Diehl
13. Birthplace Md
MOTHER 14. Maiden name Susie Strevig
15. Birthplace Md
16. Informant Mrs. Mervin Diehl
Address Taneytown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 31 1946 (month) (day) (year)
Cemetery or crematory Pleasant Valley Cemetery
Location Pleasant Valley, Md.
18. Funeral director C O Fuss & Son
Address Taneytown, Md.
19. August 31 1946 Ethel M Metzring
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1946 at 9:50 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 20 1946 to Aug. 28 1946 and that I last saw him alive on Aug. 28 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	8 days
Due to Hypertension & Arteriosclerosis	5 yrs.
Due to	
Other conditions Chronic Nephritis, Chronic Myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operation None Date of op.
Autopsy results Not Done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE R. S. McVaugh M. D.
M. D. or other
Address Taneytown, Md. Date signed Aug. 30 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07980

1. PLACE OF DEATH:
County Carroll
City or town New Windsor R.D. #1 (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Weeks
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster (If outside city or town limits, write RURAL and give nearest town)
Street No. Doyle Ave. (If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME William Ernest Diehl

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Ora Gitt
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) March 26 - 1872

8. AGE: Years	Months	Days	If less than one day
74	4	26	..... hrs. ..... min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual occupation Farmer, Ret.
11. Industry or business
FATHER 12. Name Samuel Diehl
13. Birthplace Carroll Co. Md.
MOTHER 14. Maiden name Sarah Ann Haines
15. Birthplace Carroll Co. Md.
16. Informant Mrs Frank Hoover
Address New Windsor, Md. R.D. #1
17. Burial (Burial, cremation, or removal. Which?) Date thereof August 20 1946 (month) (day) (year)
Cemetery or crematory Pipe creek Cemetery
Location New Windsor Md.
18. Funeral director H Bankard & Son
Address Westminster, Md.
19. Aug 20 1946 (Date rec'd by registrar) Ervin L Bynde Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1946 at 10:20 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1945 to August 17 1946
and that I last saw him alive on August 17 1946

Immediate cause of death	DURATION
Carcinoma	11 mos
ascending colon	
c metastases	
Due to Secondary anemia	
Cachexia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

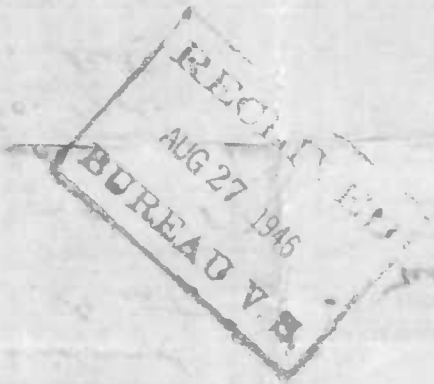
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE. W Glenn Loucher M. D. or other
Address Westminster Md. Date signed 8/19/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


AUG 27 1946
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07904

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 12 days

Hospital, Institution, or street address where death occurred:
Md. Tuberculosis Sanatroium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 506 N. Bruce Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: JULIA DIGGS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	widow

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth data of deceased (mo., day, yr.): March 21, 1876

8. AGE: Years	Months	Days	If less than one day
70	4	10	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER — 12. Name: Kenneth Carter

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Camilla Jackson

15. Birthplace: Unknown

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal, Which?) Date thereof Aug. 15-46 (month) (day) (year)

Cemetery or crematory: Mt. Auburn.

Location: Baltimore City

18. Funeral director: Geo. G. Kelson

Address: 1303 Presstman St.

19. 8/11 (Date rec'd by registrar) 19 46 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug., 11, 19 46 at 3.00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29, 19 46, to Aug. 11, 19 46 and that I last saw her alive on August 11, 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Reuben W. Swan, M.D.
M. D. or other

Address: Henryton, Md. Date signed 8/11/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore

07905

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 2 mos., 23 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St. Mary's
City or town: Charlotte Hall
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: DOROTHY ELIZABETH DOUGLAS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): January 6, 1928

8. AGE:	Years	Months	Days	If less than one day
	18	7	21	hrs. min.

9. Birthplace: Charlotte Hall, Maryland (Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Francis Gross
13. Birthplace: Unknown

MOTHER
14. Maiden name: Eva Douglas
15. Birthplace: Charlotte Hall, Md.

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 30 1946 (month) (day) (year)
Cemetery or crematory: Ebenezer Cemetery
Location: New Market St. Mary's Co.
18. Funeral director: Benedict Robinson
Address: Leonardtown Md.

19. Aug. 27, 1946 (Date rec'd by registrar) Albert R. Swann Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 27, 1946 at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4, 1945 to Aug. 27, 1946 and that I last saw h... alive on August 27, 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	April 17 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben M. Swann, M.D.
M. D. or other
Address: Henryton, Md. Date signed 8-27-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07906 74
Reg. Dist. No.

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 17 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1622 E. Lombard Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: WILLIAM ELLISON

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Martha Ellison
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 12, 1894

8. AGE:	Years	Months	Days	If less than one day
	52	4	0	hrs. min.

9. Birthplace: Greensville, N. C.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: William Ellison
13. Birthplace: North Carolina
MOTHER 14. Maiden name: Harriet (Unknown)
15. Birthplace: North Carolina
16. Informant: Deceased
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 15-46 (month) (day) (year)
Cemetery or crematory: Greenville, N.C.
Location
18. Funeral director: Geo. D. Kelson
Address: 1303 Presstman St.
19. 8/12 (Date rec'd by registrar) 1946 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 12, 1946, at 6.55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25, 1946, to Aug. 12, 1946 and that I last saw him alive on August 12, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Fraser, M.D.
M. D. or other
Address: Henryton, Md. Date signed 8/12/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
MARGIN RESERVED FOR BINDING
VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

07907 46

Reg. Dist. No. 46

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. Winnert Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Grant Gernett

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Ida Ulrich
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 28 - 1869

8. AGE:	Years	Months	Days	If less than one day
	76	7	28	....hrs. ....min.

9. Birthplace Lebanon Co. Pa.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Aaron Gernett
13. Birthplace Pa.
MOTHER 14. Maiden name Mary Myerley
15. Birthplace Pa.
16. Informant Daniel Graybill
Address Westminster, Md. RD #3
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 10-1946 (month) (day) (year)
Cemetery or crematory Stough Cem. Dauphin Co. Pa.
Location Colonial Park, Pa.
18. Funeral director H. Bankard & Son
Address Westminster Md.
19. (Date rec'd by registrar) 8-9-46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1946, at ~ M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1944, to Aug 8 1946
and that I last saw him alive on Aug 5, 1946

	DURATION
Immediate cause of death	
Myocardial degeneration	2 yrs
Due to. arterio sclerosis	Indefinite
Due to.	
Other conditions Senile (or toxic) dementia	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reese Wilbers M.D.
M. D. or other
Address Westminster Md. Date signed 8/8/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07908

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 month, 14 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1728 E. Madison Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME CLARA ANN HAMILTON

3.(b) Social Security Number 217-12-7473

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1909

8. AGE: Years	Months	Days	If less than one day
37	2	3	hrs. min.

9. Birthplace Prince George's Co., Md.
(Town, county, and state)

10. Usual occupation Dish Washer

11. Industry or business

FATHER 12. Name George Hamilton
13. Birthplace Brooks, Md.

MOTHER 14. Maiden name Mary Louise Thomas
15. Birthplace Clinton, Md.

16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 17th/46 (month) (day) (year)
Cemetery or crematory M. t Calvery Cemetery
Location Brookland Md
18. Funeral director Elmer O. Wilson
Address 1000 Brantley Ave.

19. 8/14 (Date rec'd by registrar) 19 46 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14, 1946 at 1.00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30, 1946 to Aug. 14, 1946 and that I last saw her alive on August 14, 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	3/28/46
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben H. Ewan M.D.
M. D. or other
Address Henryton, Md Date signed 8/14/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07909

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 6 Mo's., 11 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Truners Station
(If outside city or town limits, write RURAL and give nearest town)
Street No. 633 Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: ANNIE MAE HENDRIX

3.(b) Social Security Number: 213-12-6887

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: George Hendrix

8.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): May 7, 1917

8. AGE:	Years	Months	Days	If less than one day
	29	3	6	....hrs. ....min.

9. Birthplace: Columbia, S. C.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Ebell Williamson
13. Birthplace: Columbia, S.C.

MOTHER
14. Maiden name: Clotel Posey
15. Birthplace: Columbia, S. C.

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/16/46 (month) (day) (year)
Cemetery or crematory Mt Calvary
Location A. A. Co. Md
18. Funeral director Mrs Robert S Elliott + daughter
Address 1129 N. Caroline St.

19. 8/13 (Date rec'd by registrar) 19 46 Allen R. Smallwood Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1946 at 8.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 22, 1945 to Aug. 13, 1946
and that I last saw her alive on August 13, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1941
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M. D. M. D. or other
Address Henryton, Md. Date signed 8/13/46

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

P 07910

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Balto. Carroll Co.

City or town: Hatther, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Pikesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 20 N. Waldron Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Isaac William Hines.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jennie D.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Apr. 22, 1865

8. AGE: Years	Months	Days	If less than one day
81	3	22	..... hrs. ..... min.

9. Birthplace: Charlestown, Maryland (Town, county, and state)

10. Usual occupation: Retired (Salesman)

11. Industry or business: Clothing

FATHER — 12. Name: John Hines

FATHER — 13. Birthplace: Kent Co. Maryland

MOTHER — 14. Maiden name: Elizabeth Birchhead

MOTHER — 15. Birthplace: Kent Co. Maryland

16. Informant: Mrs. Jennie D. Hines

Address: 20 N. Waldron Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-21-46 (month) (day) (year)

Cemetery or crematory: Woodlawn

Location: Woodlawn, Maryland

18. Funeral director: Loring Byers

Address: 5005 Park Heights Ave

19. 8/21 19 46 (Date rec'd by registrar) A. W. Tedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 18, 1946, at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1943 to August 18th 1946 and that I last saw h.. alive on August 17th 1946

Immediate cause of death	DURATION
Cerebral Thrombosis	2 wks.
Due to: Art. Sclerosis	3 yrs.
Due to:	
Other conditions: Coronary Sclerosis	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James A. Miller M.D. M. D. or other

Address: Pikesville, Md. Date signed: 8/20/46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)(a)

CERTIFICATE OF DEATH

07911 76
Reg. Dist. No.

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, Institution, or street address where death occurred:
Fringer Norsing Home
How long in hospital or institution? 4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 234 E. Main St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Anna May Horn

3.(b) Social Security Number: 213-05-1605

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: William R. Horn
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 2, 1895

8. AGE: Years	Months	Days	If less than one day
51	7	8	hrs. min.

9. Birthplace: Hagerstwon, Md.
(Town, county, and state)
10. Usual occupation: labor
11. Industry or business:
FATHER 12. Name: Charles Springer
13. Birthplace: Maryland
MOTHER 14. Maiden name: Not known
15. Birthplace: " "
16. Informant: Miss Emma Horn
Address: Westminster, Md.
17. burial (Burial, cremation, or removal. Which?) Date thereof 8/13/46 (month) (day) (year)
Cemetery or crematory: Westminster Cemetery
Location: Westminster, Md.
18. Funeral director: J. Francis Reese
Address: Westminster, Md.
19. 8/12 (Date rec'd by registrar) 19 46 L. K. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10 19 46 at 11 a. m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 35 to Aug 10 19 46 and that I last saw h[er] alive on Aug 9 19 46

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 hrs.
Due to: Myocarditis (Chr)	
Due to: Nephritis (Chr)	
Due to: Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. C. Jonnette M. D. or other
Address: Westminster Md. Date signed 8-10-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 07913 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 119 N. Schroeder St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: SADIE JACKSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	widowed

B.(b) Name of husband or wife

B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 20, 1908

8. AGE: Years	Months	Days	If less than one day
38	3	15	hrs. min.

9. Birthplace: Darlington, S.C.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER 12. Name: Eddie Stevenson
13. Birthplace: Darlington, S.C.

MOTHER 14. Maiden name: Lillie Pauley
15. Birthplace: Darlington, S.C.

16. Informant: Edna Lunn (Sister)
Address: 917 W. Fayette St., Balto.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 (month) 10 (day) 46 (year)

Cemetery or crematory: Mount Gon
Location: Balto Md

19. Funeral director: Kate J. Williams
Address: 3224 E Chrondin

19. Aug. 5, 1946 (Date rec'd by registrar) Albert R. Counselman Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5, 1946, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20, 1946 to August 5, 1946 and that I last saw her alive on August 5, 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	May 11th 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed 8-5-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(13) 07913

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 4 mos., 14 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 818 N. Carrollton Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: LEROY JAMES

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 6, 1905

8. AGE: Years	Months	Days	If less than one day
40	11	24	hrs. min.

9. Birthplace: Augusta, Georgia
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: Sumpter James
13. Birthplace: Unknown

MOTHER
14. Maiden name: Sarah Morton
15. Birthplace: South Carolina

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/3/46 (month) (day) (year)
Cemetery or crematory: Mt. Lebanon Cemetery
Location: Baltimore, Md.
18. Funeral director: Chas. L. Artis
Address: 510-512 Carrollton Ave.
19. Aug. 30, 1946 (Date rec'd by registrar) Albert B. Swanhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 30, 1946 at 3:50 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16, 1945 to Aug. 30, 1946 and that I last saw h... im alive on August 30, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1943
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 8-30-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07914

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr, 4 mo's, 1 day
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If ontside city or town limits, write RURAL and give nearest town)
Street No.: 26 Northwest Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MARIE VIVIAN JOHNSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 8, 1915

8. AGE: Years	Months	Days	If less than one day
31	1	6	hrs. min.

9. Birthplace: Annapolis, Md.
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business:

FATHER
12. Name: Aaron Johnson
13. Birthplace: Annapolis, Md.

MOTHER
14. Maiden name: Martha Johnson
15. Birthplace: Annapolis, Md.

16. Informant: Deceased
Address:

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: AUG. 18, (month) (day) (year)
Cemetery or crematory: BROWN HILL
Location: ANNAPOLIS MD
18. Funeral director: ETHEL. HICKS
Address: 143 NORTH W. ST
Annapolis, Md.
19. 8/14 (Date rec'd by registrar) 19 46 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14, 19 46, at 7.35P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13, 19 45 to Aug. 14, 19 46
and that I last saw her alive on August 14, 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1944
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Foreman M. D.
M. D. or other
Address: Henryton, Md. Date signed: 8/14/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07915

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Taylorsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 yrs 7 mos

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 16 yrs 7 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: "

City or town: Taylorsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Betty Keyser

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife: George K Keyser

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct 3d 1865

8. AGE:

Years	Months	Days	If less than one day
80	10	25	..... hrs. ..... min.

9. Birthplace: md.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER 12. Name: Alvin Stump

13. Birthplace: Germany

MOTHER 14. Maiden name: Ella Shelby

15. Birthplace: Germany.

16. Informant: Mrs Katie Zook

Address: Hagerstown md.

17. Burial (Burial, cremation, or removal, which?) Date thereof 8-31-46 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown md

18. Funeral director: C M Lester & Sons

Address: 305 N Potomac st

19. Aug. 28 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 28 1946, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 31 1931, to Aug 28 1946 and that I last saw h.. alive on Aug 28 1946

Immediate cause of death	DURATION
Chronic Myocarditis	10 yrs
Due to	
Epilepsy	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W W Wastin M.D.
M. D. or other

Address: Taylorsville md Date signed 9/27/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

P 07916

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 yrs. 2 mo. 22 da.

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 37 yrs. 2 mo. 22 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County .....

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1702 Harford Avenue (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Annie Koestler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE:	Years	Months	Days	If less than one day
Probable	69			..... hrs. ..... min.

9. Birthplace Baltimore, Maryland. (Town, county, and state)

10. Usual occupation none

11. Industry or business none

FATHER 12. Name Jacob Koestler

FATHER 13. Birthplace Germany

MOTHER 14. Maiden name unknown

MOTHER 15. Birthplace Germany

16. Informant Hospital Records

Address Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 13 1946 (month) (day) (year)

Cemetery or crematory Holy Redeemer

Location Baltimore

18. Funeral director Rita Wiedefeld

Address 900 E. Biddle St.

19. 8/12 1946 (Date rec'd by registrar) A W Fedrick Registrar

J.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3, 1946 at 6/30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 1946 to August 3, 1946

and that I last saw her alive on August 2, 1946

Immediate cause of death	DURATION
General Arteriosclerosis	10 yrs.
Due to	.....
Due to	.....
Other conditions Pulmonary Oedema	12 hrs.

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Dr. Maud M. Peet M. D. or other

Address Sykesville, Md. Date signed 8-3-46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (168)

Registered No. 74

07017

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rural near Sykesville
(c) Hospital or institution: Carroll County, Md
Springfield State Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs. 9 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Hagerstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Frank Miller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ or wife Viola B
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1858

8. AGE: Years	Months	Days	If less than one day
88	5	23	hr. min.

9. Birthplace Indiana
(Town, county, and state)
10. Usual Occupation Retail Men's Clothing
11. Industry or business

FATHER
12. Name John F. Miller
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Martha Metz
15. Birthplace Pennsylvania

16 (a) Informant Springfield State Hosp. Rec'd
(b) Address Sykesville, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-46 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Hagerstown, Md.

18 (a) Funeral director C. M. Suter & Sons
(b) Address Hagerstown, Md.

19 (a) Aug. 18, 1946 (Date rec'd by registrar) (b) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16, 1946, at 4:05 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage, multiple fractures

Due to

Other Conditions Multiple lacerations, bruises and abrasions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-15-46 at 10:15 P. M.
(b) Where did injury occur Springfield State Hosp.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Blunt force

23. Signature Howard J. Maddox M.D.
Medical Examiner.
Date signed 8-17-46

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07918

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 month, 8 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1116 E. Lombard St.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: BERTHA MORRIS

3.(b) Social Security Number: 220-24-5762

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Samuel Morris
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 4, 1909

8. AGE: Years	Months	Days	If less than one day
37	3	16	hrs. min.

9. Birthplace: Preston, Ga.
(Town, county, and state)
10. Usual occupation: Waitress
11. Industry or business
FATHER 12. Name: Julius Young Williams
13. Birthplace: Preston, Ga.
MOTHER 14. Maiden name: Willie Williams
15. Birthplace: Preston, Ga.
16. Informant: Deceased
Address
17. Shipped (Burial, cremation, or removal. Which?) Date thereof 8/22/46 (month) (day) (year)
Cemetery or crematory
Location: Macon, Ga.
18. Funeral director: Mrs. Robt. Elliott & Daughter
Address: 1129 N. Caroline St.
19. 8/20 (Date rec'd by registrar) 1946 Albert L. Swan Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20, 1946 at 1.15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1946 to Aug. 20, 1946 and that I last saw her alive on August 20, 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Jan. 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Swan, M.D.
M. D. or other
Address: Henryton, Md Date signed 8/20/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

07919

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH:
County: Carroll
City or town: Flohrville, rural nr Sykesville
(If nntside city nr town limits, write RURAL and give nearest town)
How long in above place of death? 14 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: rural near Sykesville
(If nutside city nr town limits, write RURAL and give nearest town)
Street No.: Flohrville
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Robert Andrew Norris

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

8.(b) Name of husband or wife: Marie Elizabeth Gernand
8.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): August 1, 1899

8. AGE: Years	Months	Days	If less than one day
47	--	14	hrs. min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)
10. Usual occupation: stationary engineer
11. Industry or business: public institution

FATHER
12. Name: Cecil Smith Norris
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Kearney
15. Birthplace: Harford County, Maryland

16. Informant: Marie, Louis & Cecil Norris
Address: Sykesville, Maryland

17. Burial (Burial, cremation, nr removal: Which?) Date thereof 8-19-46 (month) (day) (year)
Cemetery or crematory: Supreme Park Cemetery
Location: Woodlawn, Balto. Md.

18. Funeral director: C. Harry Wen
Address: Sykesville, Md.

19. Aug. 17 1946 (Date rec'd by registrar) C. Harry Wen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15 1946, at 11:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 1946, to Aug. 15 1946
and that I last saw him alive on August 15 1946

	DURATION
Immediate cause of death: Coronary occlusion	instant
Due to: Hypertensive cardiovascular disease,	of more than 1 yr.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: lumbar sympathectomy
Date of op. Nov. 1945
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
M. D. or other
Address: Sykesville, Maryland Date signed 8-16-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07920

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs 11 mo 17 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 3 yrs 11 mo 17 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Westernport (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Troell B Ordner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1916

8. AGE: Years: 30 | Months: 7 | Days: 4 | If less than one day: hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Carpentry

11. Industry or business: Lathing

FATHER — 12. Name: Charles J Ordner

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Pearl Hanlan

MOTHER — 15. Birthplace: Md

16. Informant: Charles J Ordner. Address: 410 Vine St. Westernport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 15 1946 (month) (day) (year)

Cemetery or crematory: Westernport

Location: Allegany Co., Md.

18. Funeral director: D. L. Boal

Address: Westernport, Md.

19. Aug 13 1946 (Date rec'd by registrar) C. Henry Wood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 12 1946 at 3-05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 26 th 1942 to Aug 12 1946 and that I last saw him alive on Aug 12 1946

Immediate cause of death	DURATION
Lobar Pneumonia	1 wks.
Due to:	
Due to: Epilepsy	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W Gaston M.D. M. D. or other

Address: Sykesville Date signed: 8/12/46

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

07921 (76 / 77)

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Hunksburg – Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Hunksburg – (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Helen Marshall Potter

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Ft	W	widow

6.(b) Name of husband ~~or wife~~: Arthur W Potter Jr
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 22 – 1863

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
82	8	17		

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: None
11. Industry or business:
FATHER 12. Name: James Marshall
13. Birthplace: Maryland
MOTHER 14. Maiden name: Harris
15. Birthplace: Maryland
16. Informant: Arthur W Potter 3rd
Address: Reisterstown Md
17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Aug 9/46 (month) (day) (year)
Cemetery or crematory: Greenmount Cem.
Location: Baltimore Md
18. Funeral director: Edwin Tipton
Address: Hampstead
19. August 7 1946 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6 1946, at 9:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946 to Aug. 6 1946
and that I last saw h[illegible] alive on August 6 1946

Immediate cause of death	DURATION
Cerebral Thrombosis	5 days
Due to: Arterio Sclerosis	10 yrs
Due to:	
Other conditions: Diabetes Mellitus	20 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Maurice C. Porter Jr. M.D. or other
Address: Hampstead Md Date signed: 8-8-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07922

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 month, 13 days
Hospital, institution, or street address where death occurred:
Maryland Tub erculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1705 W. Lanvale Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: BESSIE POWELL (BESSIE HARRIS POWELL)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Louis Powell
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 1, 1918

8. AGE:	Years	Months	Days	If less than one day
	28	4	24	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Samuel T. Harris
13. Birthplace: Maryland

MOTHER
14. Maiden name: Bessie Daphney
15. Birthplace: Maryland

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-28-46 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: A. A. Co. Md.
18. Funeral director: Samuel W. Bloom & Son
Address: 638 N. Gilmor St. Balto

19. 8/25 (Date rec'd by registrar) 1946 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25, 1946 at 6.00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1946 to Aug. 25, 1946 and that I last saw her alive on Aug. 25, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1946
Due to	
Due to	
Other conditions	

(include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben H. Freeman M. D.
M. D. or other
Address: Henryton, Md. Date signed 8/25/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07923

CERTIFICATE OF DEATH

★ Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months, 20 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1520 Orleans Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: GLADYS JUANITA PRICE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 21, 1927

8. AGE: Years	Months	Days	If less than one day
19	1	13	hrs. min.

9. Birthplace: Littleton, N.C. (Town, county, and state)
10. Usual occupation: Laundry Worker
11. Industry or business

FATHER
12. Name: Charles Price
13. Birthplace: North Carolina

MOTHER
14. Maiden name: RuthPerry
15. Birthplace: North Carolina

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 7 1946 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: Brooklyn, Md
18. Funeral director: Elroy S. Wilson
Address: 1000 Bentley ave

19. Aug. 4, 1946 (Date rec'd by registrar) Albert R. Swanborg Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4, 1946, at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 14, 1945 to Aug. 4, 1946 and that I last saw her alive on August 4, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Inman M.D. M. D. or other
Address: Henryton, Md. Date signed: 8-4-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-D

CERTIFICATE OF DEATH

07924

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Hampstead
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Hampstead
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James E Rhoten

3.(b) Social Security Number -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Sadie E Rhoten

6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): April 9 - 1864

8. AGE: Years 82 | Months 4 | Days 16 | If less than one day ... hrs. ... min.

9. Birthplace: Md (Town, county and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER 12. Name: George Rhoten
13. Birthplace: Md

MOTHER 14. Maiden name: Corey Miles
15. Birthplace: Md

16. Informant: Mrs James E Rhoten
Address: Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 28/46 (month) (day) (year)
Cemetery or crematory: St Paul's
Location: Balto Co Md

18. Funeral director: Edw C Tipton
Address: Hampstead Md

19. Aug 26 1946 (Date rec'd by registrar) John E. Hughes Jr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25 1946 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1946 to Aug 25 1946 and that I last saw him alive on Aug 25 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to Hypertension & Cardio-Vascular disease	15 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Maurice C. Porterfield M. D. or other
Address: Hampstead Date signed: 8-25-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07925

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 25 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: West Street Branch P.O.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: CHARLES HENRY ROBINSON

3.(b) Social Security Number: 216-07-5469

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Osceola Robinson
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): January 26, 1899

8. AGE: Years	Months	Days	If less than one day
47	6	8	...hrs. ...min.

9. Birthplace: Downingtown, Pa. (Town, county, and state)
10. Usual occupation: Merchant Seaman
11. Industry or business
FATHER 12. Name: Henry Robinson
FATHER 13. Birthplace: Richmond, Va.
MOTHER 14. Maiden name: Florence Johnson
MOTHER 15. Birthplace: Berkley, Va.
16. Informant: Deceased
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8-7-46 (month) (day) (year)
Cemetery or crematory: Brewer Hill Cemetery
Location: West St., E/S Annapolis
18. Funeral director: Ethel L. Hicks
Address: 45 Northwest St. Annapolis
19. Aug. 4, 1946 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4, 1946, at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 9, 1946 to Aug. 4, 1946 and that I last saw him alive on August 4, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Reuben W. Kuman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 8-4-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

07926

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37)

CERTIFICATE OF DEATH

Reg. Diat. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 13 Ridge Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Anna Maria Royer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: John T. Royer
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 20, 1868

8. AGE: Years	Months	Days	If less than one day
78	5	3	hrs. min.

9. Birthplace: Detour, Maryland (Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Samuel Weybright
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Ann Snader
15. Birthplace: Maryland

16. Informant: Mrs. Edgar H. Royer
Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 8/25/46 (month) (day) (year)
Cemetery or crematory: Meadow Branch Cemetery
Location: Westminster, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 8/24 1946 (Date rec'd by regis(rar)) H. Kuhn Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 23 1946, at 5 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1, 1946 to Aug 23 1946 and that I last saw her alive on Aug 21 1946

	DURATION
Immediate cause of death: Myocardial degeneration	2 yrs
Due to: arteriosclerosis	indefinite
Due to:	
Other conditions: Senile tuberculosis probably arteriosclerotic	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Reese Wilbern M. D. or other
Address: Westminster Md Date signed: 8/23/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

07927

★Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Hampstead Md Rural (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Temporary 1 hour
Hospital, institution, or street address where death occurred: Gross Mill Road
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Fowblesburg Md. (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Joyce Ann Seipp

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	infant

6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) August 1, 1946

8. AGE: Years — Months — Days — If less than one day 1 hrs. 0 min.

9. Birthplace Hampstead, Carroll Co. Md. (Town, county, and state)
10. Usual occupation —
11. Industry or business —

FATHER
12. Name Wm. Warfield Seipp.
13. Birthplace Hampstead Md.

MOTHER
14. Maiden name Minnie Gertrude Seipp.
15. Birthplace Parkton Md.

16. Informant Wm Warfield Seipp.
Address Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof aug 1/46 (month) (day) (year)
Cemetery or crematory Wesley
Location Carroll Co Md
18. Funeral director Eder & Tipton
Address Hampstead Md

19. Aug. 2 1946 (Date rec'd by registrar) John S. Hughes Jr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 1946, at 11 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 1946, to August 1 1946
and that I last saw h.a.r. alive on August 1. 1946.

Immediate cause of death — DURATION
Due to Pre-Maturity. (6 Mo. Gestation)
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE Joseph E. Beach M.D. M. D. or other
Address Hampstead Md. Date signed 8-1-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07928

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 632 Perkins Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ROBERT E. SEWELL alias Raymond R. Sewell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 14, 1908

8. AGE: Years	Months	Days	If less than one day
38	1	11	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Joseph Sewell
13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Jane Sewell
15. Birthplace: Prince Frederick, Md.

16. Informant: Deceased
Address:

17. (Burial, cremation, or removal. Which?) Burial — Date thereof (month) (day) (year) 8/19/46

Cemetery or crematory: Mt Auburn

Location: Balto - Md

18. Funeral director: Chas. J. Cooper

Address: 510-512 Cantelon Ave.

19. (Date rec'd by registrar) 8/15 19 46 — Albert R. Swanborn, Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15, 1946 at 8.00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15, 1946 to Aug. 15, 1946 and that I last saw him alive on August 15, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Mar. 15 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Ruan, M.D.
M. D. or other

Address: Henryton, Md. Date signed: 8/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

07929

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 mo 25 da

Hospital, Institution, or street address (if not in hospital): Springfield State Hospital

How long in hospital or institution? 10 mo 25 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. — (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Gertrude Ridgeway Seymour

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 3d - 1865

8. AGE: Years 81 | Months 2 | Days 27 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: housework

11. Industry or business: At home

FATHER — 12. Name: Robert Seymour

FATHER — 13. Birthplace: St Inigoes Md

MOTHER — 14. Maiden name: Malinda Stoker

MOTHER — 15. Birthplace: Md

18. Informant: Mrs Elsie Saulsbury

Address: 401 Garrison Bldg. Balto.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-2-46 (month) (day) (year)

Cemetery or crematory: London Park am.

Location: Balto. Md.

18. Funeral director: Williams Comp., Inc.

Address: 1217 St Paul St.

19. Aug. 30 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 30th 1946 at 7.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 5th 1945, to Aug 30 1946 and that I last saw h[illegible] alive on Aug. 30 1946

Immediate cause of death	DURATION
Coronary thrombosis	1 wk
Due to:	
Due to: Cerebral Arterio Sclerosis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. H. Master MD M. D. or other

Address: Sykesville Md Date signed 8/31/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64a)

07930

CERTIFICATE OF DEATH

Reg. Dist. No. 7-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Rural - Uniontown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs 8 -
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Elmer Bridge Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route 1
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Charles Ellsworth Shaw

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mrs Bessie Shaw
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): December 11 - 1863

8. AGE: Years	Months	Days	If less than one day
82	8	17	hrs. min.

9. Birthplace: Carroll County Maryland (Town, county, or state)
10. Usual occupation: Farmer
11. Industry or business: Retired

FATHER
12. Name: Not Known
13. Birthplace: Not Known

MOTHER
14. Maiden name: Not Known
15. Birthplace: Not Known

16. Informant: Mrs Bessie Shaw
Address: Elmer Bridge Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 31 1946 (month) (day) (year)
Cemetery or crematory: Baust Church Cemetery
Location: along Westminster & Taneytown Road
18. Funeral director: T. M. Little & Son
Address: Littlestown PA Pa P. A. L.
19. Aug 28 1946 (Date rec'd by registrar) Margaret Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 28 1946, at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Strangulation - Hanging by neck	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 8/28/46
Where did injury occur? Uniontown (City or town) Carroll (County) Md (State)
Injured at home, farm, industry, public place (where?) None
Means of injury: Hanging by neck Injured at work?

23. SIGNATURE: James T. Thorne Deputy Medical Exam. M. D. or other
Address: Westminster Md Date signed: 8/28/46.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07931

Reg. Diat. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. S. Court
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Frederick O. Shipley

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife Elizabeth Jane Lee

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 3 - 1865

8. AGE:	Years	Months	Days	If less than one day
	90	11	5	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Farmer, Ret.

11. Industry or business

FATHER 12. Name George W. Shipley

13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden name Martha S. Shipley

15. Birthplace Md.

16. Informant Mr. Harry Flater

Address Church St, Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 11-1946 (month) (day) (year)

Cemetery or crematory Pleasant Grove Cem.

Location Sandyville, Md.

18. Funeral director H. Bankard & Son

Address Westminster, Md.

19. 8/9 (Date rec'd by registrar) 19 46 L. Maus Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8th 19 46 at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2nd 19 46 to August 8th 19 46 and that I last saw him alive on August 8th 19 46

Immediate cause of death	DURATION
Acute Hemiplegia	24 hrs.
Due to Cerebrovascular Accident	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE Hunter Barr M.D.
M. D. or other

Address 18 E. Main St. Westminster Md. Date signed 8/9/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-C)

CERTIFICATE OF DEATH

07932

Reg. Dist. No. 70

1. PLACE OF DEATH:
County: Carroll
City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mrs Bessie Virginia Sis

3. (b) Social Security Number: 216-05-4318

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: A. Roy Sis
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 25, 1883

8. AGE:

Years	Months	Days	If less than one day
63	3	4	____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business

FATHER
12. Name: Charles I Roop
13. Birthplace: Md

MOTHER
14. Maiden name: Mary C Roop
15. Birthplace: Md

16. Informant: Mr. A. Roy Sis
Address: Taneytown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 1, 1946 (month) (day) (year)
Cemetery or crematory: Keysville Cemetery
Location: Keysville, Md
18. Funeral director: C O Sauerwald & Son
Address: Taneytown, Md.

19. August 31, 1946 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 29, 1946, at 4:50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 14, 1943, to Aug. 29, 1946, and that I last saw h-e-r alive on Aug. 29, 1946

Immediate cause of death	DURATION
Malnutrition	2 wks.
Due to: Salivary Gland Adenocarcinoma involving mainly the tongue & tissues of throat	4 yrs.
Due to: Generalized Lymphatic tissue metastases	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Diagnosis Confirmed
Date of op. 1/19/43
Autopsy results: Cross Dance
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. S. McVaugh M. D. (M. D. or other)
Address: Taneytown, Md. Date signed: 8/30/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16)

07933

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 1 day
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: Reid's Grove
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. #1, box 2
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: SADIE SMULLENS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 18, 1930

8. AGE: Years	Months	Days	If less than one day
16	4	9	hrs. min.

9. Birthplace: Reid's Grove, Md.
(Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business:
FATHER 12. Name: York.
13. Birthplace:
MOTHER 14. Maiden name: York.
15. Birthplace:
16. Informant: Deceased
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 31, 1946 (month) (day) (year)
Cemetery or crematory: Reid Grove Cem.
Location: Mt. Fredericksburg, Md.
18. Funeral director: J. J. Frampton
Address: Fredericksburg, Md.
19. 8/27 (Date rec'd by registrar) 19 46 Mary A. Frampton Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 27 19 46 at 2.20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26, 19 46, to Aug. 27, 19 46 and that I last saw her alive on August 27, 19 46

Immediate cause of death	DURATION
Tuberculosis of hip and spine	Jan. 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 8/27/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07934

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months, 23 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Port Deposit
(If outside city or town limits, write RURAL and give nearest town)
Street No. 186 N. Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: DANIEL TAYLOR

3.(b) Social Security Number: 218-03-7418

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Sarah Taylor
6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): February 6, 1900

8. AGE: Years	Months	Days	If less than one day
46	6	15.	....hrs. ....min.

9. Birthplace: Port Deposit, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Daniel Taylor, Sr.
13. Birthplace: Havre-de-Grace, Md

MOTHER
14. Maiden name: Mary Reed
15. Birthplace: Port Deposit, Md.

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof aug 24 1946 (month) (day) (year)
Cemetery or crematory: St. James
Location: Havre De Grace, Md.

18. Funeral director: Wm. A. Patterson & Son
Address: Perryville, Md.

19. 8/21 (Date rec'd by registrar) 1946 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 21, 1946 at 4.15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 28, 1945 to Aug. 21, 1946 and that I last saw him alive on August 21, 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	July 1945
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed 8/21/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07935

Reg. Dist. No. 77

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mos 13 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 9 mos 13 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Annie Thomas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: George H. Thomas

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec 1860

8. AGE:

Years	Months	Days	If less than one day
85	8	1	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Seamstress

11. Industry or business:

FATHER

12. Name: Frederick Fisher

13. Birthplace: Md.

MOTHER

14. Maiden name: Sophie Fisher

15. Birthplace: Md.

16. Informant: Thomas Thomas

Address: 1541 N. Chester St. Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8-22-46 (month) (day) (year)

Cemetery or crematory: Parkwood Cem.

Location: Baltimore, Md.

18. Funeral director: Williams Cook, Inc.

Address: 1217 N. Paul St.

19. Aug. 19 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 19th 1946, at 12-20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 6th 1946, to Aug 19 1946

and that I last saw him alive on Aug 19 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	48 hrs
Due to:	
Due to: Cerebral Arteriosclerosis ?	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. H. Martin M.D. M. D. or other

Address: Sykesville Date signed: 8/19/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07936

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos., 17 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium (Colored)

How long in hospital or institution? same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick

City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 50 Lincoln Apts.

(If rural, give LOCATION)

2.(a) If veteran, name war none ✓

3. (a) FULL NAME John William Tonsil

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife Helen Tonsil

6.(c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) April 1, 1904

8. AGE: Years	Months	Days	If less than one day
42	4	16	....hrs. ....min.

9. Birthplace Frederick, Md. (Town, county, and state)

10. Usual occupation laborer

11. Industry or business

FATHER 12. Name John Tonsil

13. Birthplace Unknown

MOTHER 14. Maiden name Cora ?

15. Birthplace Unknown

16. Informant Reuben Hoffman, M.D.

Address Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-20-46 (month) (day) (year)

Cemetery or crematory Fairview Cemetery

Location Frederick, MD.

18. Funeral director M.R. Etchison & Son

Address Frederick, MD.

19. August 17 1946 (Date rec'd by registrar) Albert A Swanhart deputy local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1946, at 11:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30, 1946, to Aug. 17 1946

and that I last saw him alive on May Aug. 17 1946

Immediate cause of death	DURATION
Pulmonary tuberculosis	April 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman M.D. M. D. or other

Address Henryton, Md. Date signed 8-17-46

07937

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos., 20 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium (Colored)

How long in hospital or institution? same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1318 N. Stockton Street
(If rural, give LOCATION)

2.(a) If veteran, name war: --

3.(a) FULL NAME: JOSEPHINE LELIA TUBMAN

3.(b) Social Security Number: 216-18-4017

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 2, 1921

8. AGE:	Years	Months	Days	If less than one day
	25	0	16	hrs. min.

9. Birthplace: Grant, Maryland
(Town, county, and state)

10. Usual occupation: factory worker

11. Industry or business

FATHER — 12. Name: William Tubman

13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Olivia Harris

15. Birthplace: Grant, Maryland

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 21-46 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Baltimore City

18. Funeral director: Geo. S. Kelson

Address: 1303 Presstman St.

19. Aug. 18 1946 (Date rec'd by registrar) Albert R. Swarbman deputy local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18 1946, at 2:15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28 1946, to Aug. 18 1946

and that I last saw her alive on Aug. 18 1946

	DURATION
Immediate cause of death: Pulmonary tuberculosis	2/1/46
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other

Address: Henryton, Md. Date signed: 8-18-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

★ 17938

Reg. Dist. No. 15

1. PLACE OF DEATH:
County Carroll Co
City or town Manchester RD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Carroll Co
City or town Manchester Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Westminster Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles L Warren

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband ~~or wife~~ Marian F Warren
6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Oct 12, 1866

8. AGE: Years	Months	Days	If less than one day
79	2	12	..... hrs. ..... min.

9. Birthplace New York (Town, county, and state)
10. Usual occupation Retired
11. Industry or business none

FATHER
12. Name Unknown
13. Birthplace New York

MOTHER
14. Maiden name Unknown
15. Birthplace New York

16. Informant Marian F Warren
Address Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/13/46 (month) (day) (year)
Cemetery or crematory Druid Ridge Cemetery
Location Reisterstown Rd Balto Co

18. Funeral director David C. Martin
Address Manchester Md

19. Aug 11 1946 Mrs. W. P. L. Demmer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10 1946, at 3:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1 1946, to Aug. 10 1946
and that I last saw him alive on Aug. 6 1946

Immediate cause of death	DURATION
(a) Pneumonia	1 week
Due to Arteriosclerosis	
(b) Cardiac Insufficiency Brain Disease	4 yrs.
Due to	
Other conditions Bronchial asthma	15 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maurice C. Pattenfield M. D. or other
Address Hampstead Md Date signed Aug. 11 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (123)

CERTIFICATE OF DEATH

07939 Reg. Dist. No. 7H

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 yr., 1 mo., 29 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 24 yr., 1 mo., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: William Weiner, alias Winer, alias Wiener

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unk-

8. AGE: Years	Months	Days	If less than one day
about 51			hrs. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual occupation: cutter

11. Industry or business

FATHER 12. Name: Moses Winer

13. Birthplace: Russia

MOTHER 14. Maiden name: Blume Doun

15. Birthplace: Russia

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-16-46 (month) (day) (year)

Cemetery or crematory: Workmens Circle Cemetery

Location: Hebrew Mount Carmel Road.

18. Funeral director: Sol Levinson & Bros.

Address: 1126 N. North Ave

19. Aug. 15 1946 (Date rec'd by registrar) C. Harvey Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15 1946, at 12:15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to Aug. 15 1946 and that I last saw him alive on August 14 1946

Immediate cause of death	DURATION
Other diseases of the intestines, hemorrhage of unknown cause	18 hrs.
Due to:	
Due to:	
Other conditions: Schizophrenia, hebephrenic type	28 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.

Springfield State Hospital M. D. or other

Address: Sykesville, Maryland Date signed 8-15-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 17944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton'
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 11 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, enryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1047 N. Central Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: FRANK WILLIAMS

3.(b) Social Security Number: 218-07-3796

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Mary Williams
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): August 1, 1902

8. AGE:	Years	Months	Days	If less than one day
	44	0	12	...hrs. ...min.

9. Birthplace: Tarboro, N. C.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: Charles Williams
13. Birthplace: Unknown.

MOTHER
14. Maiden name: Mary Smith
15. Birthplace: Tarboro, N. C.

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 12th 46 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cem
Location: Baltimore Md
18. Funeral director: Elmer O Wilson
Address: 1000 Brantley Ln
19. 8/13 (Date rec'd by registrar) 19 46 Alley R Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13, 1946 at 5.55P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22, 1946 to Aug. 13, 1946 and that I last saw him alive on August 13, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Wolman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 8/13/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07941

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 726 N. Mount Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: DAVID LEE WRIGHT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 25, 1916

8. AGE:	Years	Months	Days	If less than one day
	30	3	25	hrs. min.

9. Birthplace: Chester, S. C.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Henry Wright
13. Birthplace: Chester, S. C.

MOTHER — 14. Maiden name: Emma Thomas
15. Birthplace: Chester, S. C.

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/24/46 (month) (day) (year)
Cemetery or crematory: Mt Calvery
Location: A A Co Md

18. Funeral director: Mrs Robert Elliott daughter
Address: 1129 N. Caroline St.

19. 8/20 (Date rec'd by registrar) 19 46 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20, 1946, at 11.15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 15, 1946 to Aug. 20, 1946 and that I last saw him alive on August 20, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1938
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben M Swan M.D.
M. D. or other
Address: Henryton, Md. Date signed: 8/20/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

CERTIFICATE OF DEATH

07942

Reg. Diat. No. 47

1. PLACE OF DEATH:

County: Carroll

City or town: Hampstead

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Hampstead

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME David Henry Zepp.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Sidonia Ebaugh

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): June 21-1867

8. AGE: Years 79 | Months 1 | Days 21 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired farmer.

11. Industry or business

FATHER — 12. Name: William H Zepp

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Caroline Hiniter

15. Birthplace: Maryland

16. Informant: Mrs David Zepp

Address: Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 16/46 (month) (day) (year)

Cemetery or crematory: Hampstead

Location: Hampstead Md

18. Funeral director: Edw C Tipton

Address: Hampstead Md

19. Aug. 13 1946 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 12 1946 at 4:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to Aug. 12 1946 and that I last saw him alive on Aug. 12 1946

	DURATION
Immediate cause of death: Arterio-Sclerotic Cardio-Vascular Renal Disease	5 years
Due to (or as a consequence of): Congestive Heart failure.	3 mo.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Maurice C. Porterfield M. D. or Coroner

Address: Hampstead Md Date signed: 8-12-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15